



U.S. Department of the Interior
Office of Inspector General

AUDIT REPORT

**THE REACCREDITATION PROJECT AND THE
RELATED CONTRACT WITH CONSULTANT MERCY
INTERNATIONAL HEALTH SERVICES,
GUAM MEMORIAL HOSPITAL AUTHORITY,
GOVERNMENT OF GUAM**

**REPORT NO. 95-I-78
OCTOBER 1994**



United States Department of the Interior

OFFICE OF INSPECTOR GENERAL

Washington D.C. 20240

NOV 10 1994

MEMORANDUM

TO: The Secretary

FROM: Acting Inspector General

SUBJECT SUMMARY: Final Audit Report for Your Information - "The Reaccreditation Project and the Related Contract With Consultant Mercy international Health Services, Guam Memorial Hospital Authority, Government of Guam" (No. 95-I-78)

DISCUSSION: The report concluded that the Guam Memorial Hospital Authority had effectively administered the contract with consultant Mercy International Health Services and that the consultant had fully complied with the terms of the contract. However, the Hospital had not complied with the standards established by the Joint Commission on Accreditation of Health Care Organizations. This condition occurred because the Hospital, since its last accreditation survey in 1989, had not (1) implemented an effective plan for correcting deficiencies identified by the Joint Commission, (2) ensured that its administrators would be held accountable for correcting patient care deficiencies identified in mock surveys, (3) required managers to ensure that their operations fully complied with accreditation standards, and (4) hired qualified nursing administrators and filled vacancies in essential nursing and clerical positions. As a result, although the Hospital had spent \$1.6 million to improve operations and to prepare for an accreditation survey, there was no assurance that the Hospital will regain accreditation or that it was providing quality health care to the people of Guam.

The response from the Chairman, Board of Trustees, Guam Memorial Hospital Authority, was sufficient for us to consider all five of the report's recommendations resolved.


Joyce N. Fleischman

Attachment

Prepared by: Marvin Pierce
Extension: 208-4252



United States Department of the Interior

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OCT 28 1994

LETTER AUDIT REPORT

Ms. Rosie Tainatongo
Chairperson, Board of Trustees
Guam Memorial Hospital Authority
850 Governor Carlos G. Camacho Road
Tamuning, Guam 96911

Dear Ms. Tainatongo:

Subject: Final Audit Report on the Reaccreditation Project and the Related
Contract With Consultant Mercy International Health Services, Guam
Memorial Hospital Authority, Government of Guam (No. 95-I-78)

INTRODUCTION

This report presents the results of our audit of the Guam Memorial Hospital Authority's reaccreditation project and the related contract with consultant Mercy International Health Services for fiscal years 1990 through 1993. This audit was initiated as a result of our review of a procurement of consulting services in our April 1993 audit report (No. 93-1-941) on the Hospital's management of procurement and property. The objective of our current review was to determine whether the consultant was complying with the provisions of the contract and the Hospital was administering the contract effectively and was complying with standards established by the Joint Commission on Accreditation of Health Care Organizations. According to the Hospital's budget, revenues for fiscal year 1994 were expected to be \$53 million, which included a \$10 million subsidy from Guam's general fund.

The audit showed that after 4 years of assistance from consultant Mercy International Health Services, at a cost of \$1.6 million, the Guam Memorial Hospital Authority was not ready to undergo a Joint Commission survey. As a result, there was no assurance that the Hospital will regain accreditation or that the residents of Guam will be provided quality health care services.

BACKGROUND

The Guam Memorial Hospital Authority was established in 1977 to maintain and operate a facility that provides health care services to the people of Guam and the neighboring Pacific region. The Governor appoints the hospital's seven-member Board of Trustees subject to legislative confirmation, and the Board appoints the Hospital Administrator. The Administrator, as the chief executive officer, has full charge and control over Hospital operations. On June 2, 1983, the Hospital lost its accreditation because of 24 deficiencies in the Hospital's physical plant and patient care services. To correct deficiencies identified and regain accreditation, the Hospital (1) started a renovation and expansion project in March 1986 and (2) awarded a contract in September 1989 to Mercy International Health Services, a hospital consultant, to assist the Hospital in meeting the accreditation requirements. Under the contract, the consultant was to provide a "sustained management development experience" for the Hospital's management team, with the overall goals being to improve the quality of patient care, increase the cost effectiveness of services, and raise the standards of operations to meet the Joint Commission requirements. These actions were to have prepared the Hospital to successfully pass a Joint Commission accreditation survey. This contract was extended annually through September 1993 because the Hospital (1) initially underestimated the amount of work needed to regain accreditation and (2) had to do additional work to keep pace with annual updates of Joint Commission accreditation standards. This contract was funded by \$1.1 million in local funds and a \$500,000 technical assistance grant from the U.S. Department of the Interior.

The Joint Commission on Accreditation of Health Care Organizations was established in 1951 as an independent nonprofit organization, whose mission is to improve the quality of care provided to the public in organized health care settings. Its members are the American College of Physicians; the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. The major functions of the Joint Commission include developing organizational standards, awarding accreditation certificates, and providing education and consultation to health care organizations.

In 1994, because of the public's increasing demands for accountability from health care organizations, the Joint Commission shifted the emphasis from standards that focus on capability to those that focus on performance and the outcome of patient care. These standards address patient care, organizational functions, medical staff, and specific service requirements of various hospital departments. The Joint Commission accreditation survey assesses the extent of a hospital's compliance with applicable Joint Commission standards. The extent of compliance forms the basis for determining a hospital's accreditation status. Compliance is assessed through (1) verbal information on implementation of the standards or examples of their

implementation, (2) on-site observations by Joint Commission surveyors, and (3) documentation of compliance as provided by hospital staff.

SCOPE OF AUDIT

This program results audit included a review of the consultant's contract performance and the Hospital's efforts since 1989 to regain reaccreditation. Audit work was performed at the Guam Memorial Hospital Authority and the Office of the Governor from September 1993 through April 1994.

The audit was made, as applicable, in accordance with the "Government Auditing Standards," issued by the Comptroller General of the United States. Accordingly, we included such tests of records and other auditing procedures that were considered necessary under the circumstances.

As part of the audit, we evaluated the Hospital's controls for (1) monitoring the consultant's performance under the contract and (2) correcting deficiencies, holding managers responsible for corrective actions, and tracking progress toward accreditation. We found internal control weaknesses in the methods used by the Hospital to correct deficiencies, hold managers responsible for corrective actions, and track progress toward accreditation. Our recommendations, if implemented, should improve the internal controls in these areas.

PRIOR AUDIT COVERAGE

During the past 5 years, the U.S. General Accounting Office has issued no reports that addressed accreditation at the Guam Memorial Hospital Authority. However, in April 1993, the Office of Inspector General issued the audit report "Procurement and Property Management, Guam Memorial Hospital Authority, Government of Guam" (No. 93-1-941). While the audit report commented on problems associated with the Hospital's accreditation efforts, it did not contain any recommendations regarding accreditation because this area was going to be reviewed in greater detail in our current audit.

RESULTS OF AUDIT

We found that the Guam Memorial Hospital Authority had effectively administered the contract with consultant Mercy International Health Services and that the consultant had fully complied with the terms of the contract. However, the Hospital had not complied with the standards established by the Joint Commission on Accreditation of Health Care Organizations. This condition occurred because the Hospital, since its last accreditation survey in 1989, had not (1) developed and implemented an effective plan for correcting deficiencies in a timely manner, (2) held

its administrators accountable for correcting patient care deficiencies identified in mock surveys, (3) established the requirement for managers to ensure that their operations fully complied with accreditation standards, (4) hired qualified nursing administrators, and (5) filled vacancies in essential nursing and clerical positions for the Infection Control and Employee Health Programs. As a result, there was no assurance that the Hospital will regain accreditation, even though it has spent \$1.6 million to improve operations and to prepare for an accreditation survey, and that it was providing quality health care to the people of Guam.

Mock Surveys

The consultant conducted four mock surveys¹ from September 1989 through June 1993, and the Hospital's accreditation team conducted one mock survey in February 1994. Each of the mock survey reports disclosed the Hospital's major noncompliance with standards affecting patient care and included recommendations to correct these deficiencies. The Hospital Administrator stated that he had provided oversight of the correction of mock survey deficiencies and overall accreditation progress through weekly meetings of the Executive Management Council, which consists of associate and assistant administrators. However, the deficiencies in patient care reported in the four mock surveys conducted have recurred. Although the consultant's mock surveys showed that the overall scores in the surveys had improved from 28 to 55 percent, the consultant indicated that the Hospital needs a score of 75 to 80 percent to realize full accreditation.

The consultant's annual report for 1992 cited the following major deficiencies within the Hospital: (1) the former Nursing Administrator and the Consultant's Nursing Advisor had "differing priorities"; (2) the Nursing Department's management staff had not been held accountable for attainment of goals; (3) the nursing staff functioned primarily in a "crisis mode," which made the nurses unable to deal effectively with accreditation and operational issues; (4) the Nursing Department's management did not function as a team, thus hindering progress in meeting goals; and (5) the number of licensed staff available was inadequate to meet patient census and mainland nursing standards. In the June 1993 mock survey report, the consultant stated that nursing care, which was a main factor in the accreditation decision, was not being provided in compliance with the standards and recommended that an evaluation of the effectiveness of the corrective actions be included in the Quality Improvement Program, whose objective is to improve Hospital operations.

In the February 1994 mock survey, the in-house accreditation team gave the Hospital an overall score of 49 percent, with the lowest scores occurring on the new 1994 standards for improving organizational performance, managing information, and

¹The mock survey is a key means by which a hospital can prepare for an accreditation survey.

providing leadership. More significantly, the Hospital scored "minimal compliance" and had not improved in the areas of patient care, the qualifications and competency of nursing staff, infection control, patients' rights, emergency services, special care services, medical staff credentials, and decisions relating to patient care or to assessing patients.

Specifically, the mock survey reported that patients had not been provided instructions regarding their "medications," "disease process," and "home care" and that patient privacy in the Hospital was not respected by the medical staff. The survey also cited "cluttered, untidy, and often unclean" patient care areas and found that medical/nursing reference materials were "14 to 28 years old." The survey further found that patient allergies had not been adequately documented on medication profile cards in the Pharmacy. According to the survey, the entrance to the newborn nursery did not have a security system, and mothers' wrist bands were not always checked upon their entrance to the nursery. Chief nurses, according to the survey, were "frustrated" by "apathetic staff," who were "disinterested in continuing education and resistant to progress" and were on the job "only . . . until they retire." The survey also reported that the nursing care plan was "inadequate." For example, in the surgical department, the only care plan for all the patients was for the administration of pain medications. The survey further noted that data files on medical staff practitioners were not being routinely reviewed by the appropriate Departmental chairpersons for quality improvement performance in making recommendations as to whether the practitioners should be reappointed and whether changes should be made in clinical privileges as appropriate.

Barriers to Reaccreditation

The Hospital's Quality Management Department is responsible for the Hospital's Quality Improvement Program. In this program, senior-level managers perform self-evaluations, select problem areas for improvement, recommend corrective actions, and identify indicators for evaluating the improvements. Although the Department was in a prime position to make needed improvements, the Hospital Administrator said that there was little correlation between the problems selected by the departments for emphasis and the deficiencies cited in the mock surveys. The role of the Quality Management Department was only to ensure that the semiannual reports on the status of deficiencies in the mock surveys were submitted by the Hospital departments in time for presentation to the Board of Trustees' Quality Improvement Committee. Although the Board's Committee was responsible for providing oversight of the Hospital's quality improvement activities, it had not taken any substantive action regarding the deficiencies cited in the status reports. On these reports, the reporting departments cited, without clarification, many corrective action elements as "ongoing."

We also found that management's actions to correct patient care deficiencies were inadequate. For example, on August 5, 1993, shortly after the consultant's senior administrative advisor had left Guam, the Hospital Administrator promoted employees who were not qualified, based on education or experience requirements established in the position descriptions, to the two senior-level management positions in the Nursing Department. Thus we believe that many of the problems in correcting deficiencies occurred because nurses did not have adequate leadership capabilities. We also found that the Infection Control and Employee Health Programs were inadequately staffed and that shortages of emergency room physicians and physical therapists continued because of difficulties in recruitment. Departmental and unit-specific policies and procedures for Nursing and Infection Control had not been prepared or updated as of October 1993. During October 1993, both the nursing administrator and the infection control officer stated that their areas would probably not meet accreditation standards by March/April 1994, which was the Hospital Administrator's initial target date for a Joint Commission survey.

Subsequent Developments

In its final report, dated June 30, 1993, the consultant recommended that the Hospital appoint someone to coordinate Joint Commission accreditation progress and correction of deficiencies and that it hold managers accountable for corrective actions. This recommendation was not implemented until January 19, 1994, when the Board adopted Resolution No. 94-03 approving the Accreditation Plan, which outlined tasks and targeted completion dates. Included in the Accreditation Plan were provisions for the appointment of an accreditation team, a team leader, and a full-time coordinator for overseeing the corrective action plan.

In March 1994, the accreditation team leader reported the results (overall score of 49 percent) of the February 1994 mock survey to the Board of Trustees and submitted the Hospital's action plan and timetable to prepare for the Joint Commission's December 1994 accreditation survey. However, because of the Hospital's low overall score in the mock surveys, we believe that the Hospital may achieve only conditional accreditation unless Hospital management corrects the deficiencies noted and complies with the accreditation standards.

Recommendations

We recommend that the Governor of Guam:

1. Require the Chief of Staff (or his immediate staff) to develop and implement procedures for monitoring the Hospital's accreditation project to ensure that officials responsible for preparing the Hospital for accreditation follow the

corrective action plan established by the team leader and meet the established target dates.

We recommend that the Chairperson, Board of Trustees, Guam Memorial Hospital Authority, direct the Hospital Administrator to:

2. Adhere to the Hospital's March 1994 action plan and timetable for preparing the Hospital for the December 1994 Joint Commission accreditation survey. Included in this preparation should be the expeditious correction of the deficiencies noted in the February 1994 mock survey.

3. Ensure that managers and supervisors are held accountable for maintaining accreditation standards applicable to their operations by including a statement of this responsibility as a critical element of their performance evaluation.

4. Appoint nursing administrators who are qualified in terms of education and experience standards under applicable position descriptions.

5. Fill vacant positions that are essential to the effectiveness of the Infection Control and Employee Health Programs. A national recruitment consultant should be retained for difficult-to-fill positions such as emergency room physicians and physical therapists.

Guam Memorial Hospital Authority Response

The September 29, 1994, response (Appendix 1) from the Chairperson, Board of Trustees, Guam Memorial Hospital Authority, indicated agreement with all five recommendations.

Recommendation 1. The Hospital Authority stated that the Hospital will work with the Governor's Special Assistant on Health to implement the "appropriate monitoring of progress" made in addressing corrective actions and meeting established target dates.

Recommendation 2. The Hospital Authority stated that the Hospital has approved the March 1994 action plan, has developed workplans for all departments, and is monitoring progress at the weekly meetings of the department directors.

Recommendation 3. The Hospital Authority stated that in August 1994, the Hospital hired a Director of Human Resources, who will be responsible for updating and revising all employee performance evaluations. According to the response, the revised evaluations will include requirements for employees to comply with accreditation standards.

Recommendation 4. The Housing Authority stated that the Hospital has hired a Nursing Director who has the required educational background and over 25 years of nursing experience.

Recommendation 5. The Housing Authority stated that the Hospital has recruited an Infection Control Nurse and has hired a recruiting firm to assist the Hospital in identifying qualified health care professionals for Hospital positions.

Office of Inspector General Comments

Based on the Hospital Authority's response, we consider Recommendations 4 and 5 resolved and implemented and Recommendations 1, 2, and 3 resolved but not implemented. Accordingly, the unimplemented recommendations will be referred to the Assistant Secretary - Policy, Management and Budget for tracking of implementation, and no further response to this office is required (see Appendix 2).

The Inspector General Act, Public Law 95-452, Section 5(a)(3), as amended, requires semiannual reporting to the U.S. Congress on all audit reports issued, actions taken to implement audit recommendations, and identification of each significant recommendation on which corrective action has not been taken.

Sincerely,

A handwritten signature in black ink, appearing to read "Marvin Pierce".

Marvin Pierce

Acting Assistant Inspector
General for Audits

cc: Administrator, Guam Memorial
Hospital Authority



GUAM MEMORIAL HOSPITAL AUTHORITY

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September 29, 1994

Marvin Pierce
Acting Assistant Inspector General for Audits
Office of the Inspector General
United States Department of the Interior
1550 Wilson Boulevard
Suite 401
Arlington, Virginia 22209

Subject: Draft Audit Report on the Reaccreditation Project and the Related Contract With
Consultant Mercy International Health Services, Guam Memorial Hospital
Authority, Government of Guam (Assignment No. N-IN-GUA-012-93)

Dear Mr. Pierce:

The Authority is submitting its comments on the Draft Letter Audit Report on the Hospital's Reaccreditation Project. We thank you for the opportunity to submit our comments on the report.

The first issue we would like to address is the statement that there is little correlation between the problems selected by the departments for emphasis and the deficiencies cited in the mock surveys. The hospital's quality process at that time focused on department specific issues. For example, the "indicators" identified by the Radiology department would focus on patient specific items. We would also like to clarify that these and all the other hospital-wide indicators were developed and reviewed by the Quality Assurance/Improvement Committee. Three of the four Mercy Consultants were "permanent" members of this same committee. At no time during this period did they recommend that the Quality Assurance/Improvement Committee be the forum by which deficiencies identified in the Mock Survey would be addressed.

The Accreditation status reports were presented to the Board Quality Improvement Committee as a mechanism by which the Trustees could be apprised on each department's progress. The Board's QI Committee does have oversight on the hospital's quality improvement program and through these presentations, discussions and recommendations would take place on these reports. The department head and Administrative Representative would be responsible to do necessary followup on those issues. Again, the Mercy International Advisors were a part of the Board QI Committee and did not make any recommendation that more action was needed by this particular group. The citation about the "ongoing" status reflects any department specific issues and again reflects that the process was continuously being addressed. Any items that were resolved as adjudged by the Hospital-wide and Board QI Committees would have been indicated as "closed".



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The concern identified by the auditor that there was no effective plan that was developed to address the deficiencies cited in the Mock Surveys also needs to be commented on. It needs to be made clear that the Mercy Consultants were given the “go-ahead” to work directly with the department managers and the Administrative representative to address those deficiencies. With the departure of the Mercy Consultants, the Administrative representatives continued to work with the managers in their respective areas on the deficiencies. The Administrator then followed up with those representatives or managers directly as the situation required.

The report also indicates that the Hospital needs a score of 75 to 80 percent to realize full accreditation. Please note that the Joint Commission also awards “Conditional Accreditation” to Hospital. This would mean that surveyors would come back to the Hospital within a defined period of time to ensure that appropriate corrective actions were indeed taken. There would not be any other distinction between conditional and full accreditation.

One of the serious issues facing the Nursing department is the lack of adequate numbers of professional licensed staff. This has resulted in the major focus of that department on providing direct patient care. No one should assume that the nursing staff were not interested in accreditation but the issue of providing direct care was deemed to be priority. Additionally, even though there may have been times when the vacant numbers of nurse positions were very low, there was still the issue of staff who were on either sick or annual leave. This also compounded the situation of not having enough staff to begin with. It would be a safe conclusion that most if not all of the problems in Nursing are directly related to staffing issues.

The 1994 standards had areas of new focus, which the Hospital did not have enough time to assess compliance in February 1994. Management decided that it would be a better tool. if the assessment of compliance was done without time for study and then follow with an analysis of how we needed to respond in order to come into compliance with those standards.

The issue of promoting two employees who were not qualified was done on the recommendation of the Mercy Consultants. In fact, these employees were identified by the Senior Administrative Advisor and the Nursing Consultant who at the time was given the authority to directly manage the Nursing department. The employees were recommended because of the assessment by these two consultants that they had the best potential of all our in-house nursing staff to lead the department. The Hospital Administrator recognized that they did not have the paper credentials required by Joint Commission. However, the Mercy Consultants did reassure him that they would provide training for these two employees in addition to developing an educational plan that would enable them to meet the JCAHO requirements. It was after that point that the decision to promote was made.

With respect to the citation that the Employee Health and Infection Control departments were inadequately staffed, the Authority submits that there is a continuous announcement for these positions. The difficulty has been in having qualified applicants come in. The same

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September 29, 1994

applies to the recruitment difficulties for emergency physicians and physical therapists.

In response to Recommendation 1, we will work with the Governor's Special Assistant on Health to implement appropriate monitoring of progress made in addressing corrective actions and meeting established target dates. We have had a preliminary discussion with the Special Assistant on Health and will follow up by 10/15/94.

In response to Recommendation 2, the Hospital has approved the March 1994 action plan. Workplans have been developed for all departments as related to standards in conjunction with the Quality Management Department. Progress is monitored weekly at the Department Directors meeting. This is currently ongoing.


In response to Recommendation 3, updating and appropriate revision of all employee performance evaluations is a priority. Responsibility for compliance with accreditation standards shall be factored into the evaluation. This process began with the hiring of the Director of Human Resources in August.

In response to Recommendation 4, the Authority has brought on board a Nursing director with over twenty-five years of nursing experience in addition to having the requisite educational background. This individual is in charge of managing the department and will be also responsible for further development of the program for in-house nursing management leaders.

In response to Recommendation 5, we have recruited an Infection Control Nurse from off-island as there were initially no local applicants. Since that time, we have had one applicant also apply and was interviewed. Additionally, we have engaged the services of a mainland recruitment firm for the purpose of identifying qualified healthcare professionals for positions at the Hospital. The Human Resources (Personnel Department) is coordinating this.

Thank you for the opportunity for input into the draft report. Please contact the Hospital Administrator if additional information or clarification is needed.

Sincerely,


ROSIE R. TAINATONGO
Chairperson, Board of Trustees

cc: Governor Joseph F. Ada
Sam Gillentine
Hospital Administrator

STATUS OF AUDIT REPORT RECOMMENDATIONS

Finding/Recommendation Reference	Status	Action Required
1, 2, and 3	Resolved; not implemented.	No further response to this office is required. The recommendations will be referred to the Assistant Secretary - Policy, Management and Budget for tracking of implementation.
4 and 5	Implemented.	No further action is required.

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